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*Main Article:*

Reflection on the Development of a Research Agenda in Rural Health

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Abstract

There is a dearth of literature on how research agendas have been developed. In this article, the authors reflect on the process of developing a research agenda through a case study of a rural health university centre. The aim is to contribute to understanding how a team can effectively plan research. Two leaders of the process, as well as academics external to the process, reflected on the experience and the outcome of the agenda development process. Reflections focused on three areas: (a) engagement levels, (b) power and influence, and (c) interpretation of the research agenda. First, while there was passionate discussion at

meetings and afterward, engagement levels varied. Second, the process was imbued with power and influence at multiple levels. Finally, the availability of a conceptual framework to contextualise rural and remote health research helped in interpreting the significance of the resulting research agenda. The article concludes with contrasting thoughts on the place of research agendas within contemporary neoliberal regimes of research management.

Index Terms: research agenda; research planning; rural health; research leadership; peer reflection; research management

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1. Introduction

Increasingly there is pressure on university researchers to produce outputs from quality research relevant to social and political agendas. Under financial pressure and increased accountability, universities are insisting that their academic staff gain external research funding, produce peer-reviewed publications and attract public and media attention. These markers are used to rank research institutions globally. Universities chase world rankings of research institutions based on publications and research funding to promote their institution's research as a whole. They promote specialised research topics and develop focused teams, usually with an esteemed research leader, to establish a reputation for expertise to achieve nationally competitive funding and high-ranking publications. However, within universities, researchers are assessed individually. Institutional pressure for research outcomes falls to individual researchers, creating a competitive environment not only between institutions but between researchers within the same institution. Therefore, research structures and institutions develop agendas for individual researchers, who are then assessed primarily on quantity and quality of output.

In rural health, these research pressures are problematic. Most researchers in rural health are generalist researchers who undertake research on a range of topics of local interest or need. In addition, most rural health researchers were not trained in rural health but come to rural health from other disciplines including medicine, nursing, the allied health fields, public health, mental health, sexual health, or an area of social science, most commonly geography, psychology, sociology, or anthropology. So while there is pressure for research outputs and specialisation, rural health researchers tend not to specialise but rather work on diverse projects with local partners. Track records are not developed in a specific field but an eclectic resume of locally relevant research is achieved. Because projects are locally specific, attracting nationally competitive grants and publishing in high-ranking journals is difficult to achieve. In addition, many rural researchers are either located at a distance from the main university or travel large distances to undertake their research.

Thus, the dilemma of increasing research outputs, developing a track record, and meeting university expectations of high status publications and grants is difficult for rural health researchers. Despite this, research leaders in rural health are under the same pressures as other departments to produce research outcomes. In one rural health research centre in rural Australia, the Chair of the centre developed a research agenda to focus the centre's research on rural health, develop track records and expertise in specific areas of rural health, and increase research outputs. A research agenda was not only consistent with the needs of the host university's calls for track records but also of the government department which funded the university centre as a rural health workforce initiative to achieve excellence in rural health education, research, and community engagement.

This article reports on a case study where the Chair of this university centre led a process to develop a research agenda among its eclectic research team. The aim of the article is to reflect on the process of developing a research agenda among a multidisciplinary research team in rural health to further understand the issues involved in how a research agenda can be developed. Issues identified in this reflective process can be used by others embarking on a new research agenda. Before this reflection is undertaken, some background on the research centre and the reason for a research agenda is provided.

2. Background

2.1. Why a Research Agenda for RHAC?

The new Chair of the Rural Health Academic Centre (RHAC) observed that the centre would benefit from transition from individual projects to a clear and focused research agenda. A research agenda is planned as a strategic approach to undertaking research by a group. It focuses attention on one or a few areas, supports an ongoing process of enquiry, and helps in building expertise and research track record (Becker, Fraenkel, Kerns, & Fiellin, 2013; Mueller, Curtin, Hawkins, Williams, & Lefkowitz, 1998). Research agendas enable systematic and strategic planning of research. An agenda ensures that research activities are a planned approach for a comprehensive study of a particular issue. An agenda makes it easier to develop a body of evidence from which policy recommendations can be made (Becker et al., 2013; Farmer, Clark, & Munoz, 2010; Mueller et al., 1998).

Research agendas have been developed in a variety of ways. University agendas, for example, may emerge from specific teams or leading researchers who have identified more nuanced research approaches for a particular field (Becker et al., 2013; Gedajlovic, Honig, Moore, Payne, & Wright, 2013). Becoming increasingly evidenced-based, interdisciplinary, and consultative, some agendas emerge from reviews of evidence, identification of intrinsic and extrinsic knowledge gaps (Bantjes & Kagee, 2013; Chabowski, Samiee, & Hult, 2013; Trahms, Ndofo, & Sirmon, 2013), or from consultation with experts in the field (Mett, 2004; Fazey et al., 2012). Still others have resulted from consulting with individuals who are the subjects of research (Cheyne, McCourt, & Semple, 2013; Maar, Seymour, Sanderson & Boesch, 2010; Watson, Kaltman, Townsend, Goode, & Campoli, 2013). Conceptual frameworks can also be developed into interdisciplinary research agendas that address a current issue within society (Araral & Wang, 2013; Armstrong & Jackson-Smith, 2013;

Fazey et al., 2012; Palombo, 2013; Smith, Gonin, & Besharov, 2013). Others use more than one of these approaches (Maar et al., 2010; Mett, 2004; Fazey et al., 2012).

Despite these noted examples on the various types of research agendas, there is a dearth of literature on how research agendas can be and have been developed. This article provides a review of a process of developing a research agenda in rural health. The review is based on reflections of two drivers of the process who used a framework of rural and remote health and then shared their reflections with three academics external to, but familiar with, research agenda development processes. The aim of this article is to use these reflections to identify key issues involved in the process of developing research agendas.

2.2. The Context of Rural Health

Rural health is a politically constructed endeavour in Australia (Bourke, Taylor, Humphreys, & Wakerman, 2013; Farmer, Munoz, & Threlkeld, 2012). The funding of university programs to develop evidence and trial strategies to increase the rural health workforce has produced an eclectic and somewhat unsystematic body of knowledge (Bourke et al., 2013). This is partly because rural health researchers are few in number and partly because researchers come to rural health from various disciplines and undertake research in diverse ways. In recent years, more systematic approaches have been developed to address relevant policy and advocacy issues in this field (e.g., Wakerman et al., 2008). The new Chair of a rural health centre adopted this approach with a view to developing a research agenda that would have an impact external to the centre.

RHAC is one of a series of centres funded by the Australian Government. The aim of RHAC is to address the healthcare workforce shortage in a specific rural region of Australia as well as to facilitate improved models of rural health service delivery and innovative strategies to mitigate the effects of distance on providing healthcare. These issues have been highlighted as key rural health issues in Australia (Australian Institute of Health and Welfare, 2008; Dixon & Welch, 2000; Hartley, 2004; Hays, 2002; Hemphill, Dunn, Barich, & Infante, 2007; Humphreys, Jones, Jones, & Mara, 2002; Liaw & Kilpatrick, 2008; Ranmuthugala et al., 2007; Sibley & Weiner, 2011; Smith, Humphreys, & Wilson, 2008; Wakerman et al., 2008; Wilkinson & Blue, 2002). Rural health workforce shortages is an issue central to rural health internationally (Hays, 2002; Jian, 2008; Lagacé, Desmeules, Pong, & Heng, 2007; Mitura & Bollman, 2003; Robertson, 2008; Serneels, Lindelow, Montalvo, & Barr, 2007; Sibley & Weiner, 2011; Smith, Humphreys, & Wilson, 2008). RHAC provides rural training to health students as well as support for rural health services, health professionals, and community health projects.

Therefore, staff at RHAC are mandated by the government to: (a) teach medical programs, (b) provide student placements, (c) support rural health services and their staff members, (d) facilitate initiatives aimed at improving rural and Aboriginal health and wellbeing, (e) develop strategies to increase access to services, and (f) increase the rural health workforce. Staff of RHAC are also employees of a university. At times the expectations of the government and the university do not align. For example, the government funding emphasises local projects that support specific health services to address their needs while the

university promote staff based on nationally competitive research funding and publication in highly ranked journals. Another distinctive factor of RHAC is that it is located in three different regional towns. Each is 150-250 km away from the main university campus. In addition, like other university departments in rural health, researchers at RHAC were trained in diverse disciplines and fields including medicine, nursing, public health, biology, genetics, Aboriginal health, psychology, social work, rural sociology, and anthropology.

Thus, RHAC was a team of researchers with diverse fields of training and differing research interests, who were located in different geographic regions. It is not surprising that prior to this research planning process, research at RHAC consisted of small, local projects related to specific areas of interest to particular researchers. Frequently, research projects were undertaken independently, although a few individuals collaborated from time to time. Furthermore, the potential of the team to provide an interdisciplinary research approach to rural health was not realised.

3. Process of Developing a Research Agenda

A research agenda was developed via a consultative process with staff members of RHAC. The Chair of RHAC (author J. R. Wright) designed a process to develop the centre's research direction. He asked a senior staff member (author L. Bourke) to facilitate a task group within RHAC to develop a research agenda. This process is described here from the perspective of the Chair of RHAC and the staff member assigned as facilitator of this task group. Both these individuals wrote reflections after each of the four meetings. Quotes from these written reflections have been used in this section as they represent views of the Chair and facilitator at the time. It is important to note that what is presented is from the perspective of internal participants who were driving the process.

3.1. Planning

In order to draw on the expertise and commitment of staff at RHAC, the Chair engaged all RHAC staff members in a planning process for the whole centre in 2013. Called The Darwin Project, to signal the need for RHAC to adapt to its environment and evolve its activities, all staff members were asked to join up to two of five task groups. The five task groups represented the activities undertaken by RHAC of which only one was related to research; specifically they were: (1) Workforce, (2) Education, (3) Community engagement, (4) Aboriginal health, and (5) Transforming our environment through rural health research. Furthermore, the invitation to join task groups was extended to professional as well as academic staff. Staff self-selected into the task groups.

A total of 17 academic and 11 professional staff members nominated the research task group (i.e., Transforming our environment through rural health research). Of interest is the fact that two academics with research positions chose not to select the research task group while 10 non-academics with no formal role in research, did select this task group.

The facilitator of the research task group convened four meetings over 4 months to discuss and develop a research agenda and meetings were held 3-5 weeks apart. In between meetings, smaller groups would discuss ideas and bring them to the next meeting of the

task group. Because RHAC has multiple campuses, e-mail, telephone, and video- and teleconferencing were used regularly, in combination with face-to-face communication throughout the process, as is usual RHAC practice.

Of the 28 staff members who had selected the research task group, a core group of five academics and one professional staff member attended all the meetings. Another 17 attended some but not all of the meetings, and five did not attend any. While there was strong interest in the task group at the outset, it seemed to decline over time. While some had previous commitments that made attending specific meetings difficult, the overall decline in attendance suggests a loss of interest, perhaps because initial expectations were not being met. There was, however, lively discussion and debate at each meeting and everyone in attendance made at least one comment. Furthermore, some staff members who were not able to attend meetings contributed comments, suggestions, or feedback to written proposals or earlier discussion. This suggests that there was active contribution even though attendance declined as the process progressed.

In sum, while not all expectations may have been met and some staff members may have decreased their participation, 23 people contributed in some way to the process of developing the research agenda.

3.2. Execution

The first meeting was well attended (23 staff members) and there appeared strong agreement that research should have an impact beyond the university. The participants discussed the title of the task group, and focused on the key words *community* and *environment*. There was less attention to *transformation*, although there was some discussion of the need for research to impact on policy and health services. Discussion flowed freely as the facilitator tried to determine how the group understood its task and what might be key elements to achieving it. Members with medical training were the most vocal and staff who had worked at the centre for several years also contributed much to the discussion. The professional staff, Aboriginal staff, and junior staff also contributed, but to a lesser degree.

The second meeting was also well attended (18 staff members). The discussion focused on particular research topics and themes, departing from previous discussions about transforming health in local communities. There was debate among some to prioritise key research themes that particular researchers were currently engaged in. The facilitator noted in her reflections that she “struggled to move discussion beyond debate of current research topics to identified needs in rural health and local communities” (Facilitator’s reflections, April 7, 2013). As a range of ideas circulated, the facilitator asked participants to develop key research priorities in collaboration with others in the task group. Members wanted to develop research priorities on their own, so she asked them to circulate their ideas so others could assist with the same proposal if they felt it was worthy. Staff agreed to develop and distribute half-page written summaries of proposed research themes to all task-group members 1 week prior to the third meeting.

Following this meeting, there was concern by both the Chair and the facilitator that key research areas were “not naturally arising from discussion” (Chair’s reflections, April 14,

2013) and “the group was not gaining focus” (Facilitator’s reflections, April 7, 2013). The facilitator had not wanted to prescribe topics, directions, or themes for the research agenda to enable staff in the task group to genuinely contribute to the new agenda. However, she noted after the second meeting that she questioned if an outcome would be achieved in four meetings given the unfocused discussion so far. She was concerned that the members were pursuing individual agendas rather than collaborating. Consequently, she decided to refocus the group at the next meeting in order to achieve a research agenda within four meetings. As a result of this decision, the facilitator stressed to members via e-mail, the importance of presenting written summaries of areas they would like to be considered for inclusion in the research agenda. She also emphasised in these e-mails that the research areas would be decided upon in the next meeting.

Prior to the third meeting, nine written proposals were distributed on topics of youth, community governance, the patient journey, mental health, Aboriginal health, community health, culture, education, and obesity. These were circulated to all members of the task group. Some of the nine proposals were circulated a day or two before the meeting.

At the third meeting, the facilitator insisted on focus and resolution. Fewer (14) staff members attended this meeting. Three themes of research were selected: (1) rural health workforce, (2) rural chronic ill-health, and (3) culture and rural health. These were selected based on varying levels of discussion and consensus.

At the outset of the meeting, one staff member questioned the lack of attention among all the proposed topics to workforce, emphasising that RHAC is funded as a rural workforce program. There was general agreement about this and discussion that one of the streams of research should focus on recruitment and retention of rural health professionals. Despite there not being a written proposal, rural health workforce was discussed, and quickly and unanimously accepted by all present.

After some discussion of obesity, the patient journey and mental health, there was general consensus that the topic chronic ill-health would integrate a range of proposals, including the patient journey, obesity, mental health, community health, and Aboriginal health. The Chair had been involved in the patient journey proposal and raised the idea of chronic ill-health as a means to integrate these proposals. Over time and through discussion, the group decided that chronic ill-health was more clear than “community health” and “the patient journey” and more inclusive (less specific) than “mental health and wellbeing” and “obesity.” The participants agreed that chronic ill-health was a clear label for an area of research that was a major issue in rural areas. There was general agreement that this theme would build on previous research conducted at the centre and integrate these researchers into a team. A few were passionate about this topic, most agreed, and no one present voiced disagreement.

There was much more discussion and debate about the final theme, however, which focused on proposals about youth, community health, rural community governance, Aboriginal health, and culture. The areas of youth and Aboriginal health were discussed as very specific while governance and education could be less focused on health. The facilitator and another staff member proposed the culture theme. After long discussion

about the community health and culture themes, the “culture and rural health” theme was selected. Some preferred “community health” as more understandable and others questioned the meaning of culture and what it implied. The culture and rural health theme received support from other nursing and Aboriginal researchers for including young and Aboriginal people as well as rural communities and the cultural interaction between rural health consumers and health services. After a long discussion considering multiple proposals, the majority of those at the meeting agreed on the culture and rural health theme. Following the meeting, there was further “resistance to the culture theme in e-mail discussion by some members who had not attended the meeting” (Facilitator’s reflections, April 27, 2013) which in turn “strengthened support from other members” via e-mail responses from both attendees and non-attendees. Engagement extended beyond the meeting among 20 staff members who continued the conversation regarding the culture and rural health theme. Interestingly, two research themes that had not been proposed were generally accepted while the third (culture and rural health) had been proposed and yet raised significant debate.

The final meeting, 5 weeks later, was attended by eight staff members. The discussion focused on how each research theme would be undertaken in a 10-year process, thus outlining the research agenda (see Table 1). While workforce and chronic ill-health were accepted, there was more discussion about the meaning of culture when imagining research outcomes expected in 10 years. Given fewer attendees, the research agenda was circulated for comment, discussion, and feedback. The facilitator reflected that those who did not attend the final meeting tended to include junior and part-time researchers and some professional staff.

Table 1. *Summary of the Rural Health Research Agenda*

Research Theme	Outline of Agenda		
	Objective	Stepping Stones	Outcome
Rural Health Workforce	To contribute quality evidence that informs health services and others of the rural health workforce needs, trends, and effective strategies in our regions.	<ul style="list-style-type: none"> • Review key literature on rural health workforce recruitment, retention, education and training, and skilling. • Baseline assessment of workforce needs in our regions completed and targeted approaches identified. • Working with health services to address the workforce needs in our regions by implementing evidence-based strategies (in targeted recruitment, key retention plans, and educational approaches) and evaluating their effectiveness. 	To build evidence of how to successfully recruit and retain an appropriately skilled health workforce in our regions who are trained and supported in managing the stressors of working in rural health.

Research Theme	Outline of Agenda		
	Objective	Stepping Stones	Outcome
Rural Chronic Ill-Health	To contribute evidence to inform the prevention and management of chronic illnesses among rural people in our regions.	<ul style="list-style-type: none"> • Initial secondary data analysis to develop an epidemiological analysis of chronic disease across the population in our regions. • Work with local health and human service providers to collect and analyse data, and then implement prevention and management strategies aimed at cardiovascular disease, obesity, and mental illness. • A pilot research project will track patient care in the community and hospitalisation for chronic illness will have begun allowing the formation of longitudinal data collection. • Longitudinal data collection is well established with studies following patient care underway; strategies trialing prevention and management of chronic illness and interventions modified to increase effectiveness. 	To inform the development of effective approaches that will improve the management of chronic conditions as well as prevent onset of chronic conditions in our regions in order to develop healthy communities.
Culture and Rural Health	To develop evidence of how health systems/services in our regions can become more culturally inclusive by working with local health services and health consumer groups.	<ul style="list-style-type: none"> • Build a team within RHAC to develop a framework for understanding culture and rural health, considering the dominance of particular cultural values. • Develop, implement, and begin evaluation of a framework for how culture impacts rural health care. • Projects pursuing the relationship between culture and rural health among particular cultural groups (including Aboriginal communities, women, refugees, young people, and those with specific conditions/needs). • Research surrounding culturally inclusive rural health services is underway. A framework has been developed, implemented, evaluated, and revised. 	RHAC works with health services and communities across our regions to become more inclusive of cultural diversity, leading to better engagement of these populations by health services and better health outcomes for these groups.

4. Reflection on Development of the Research Agenda

After each of the four major meetings in the planning process, the Chair and the facilitator (authors J. R. Wright and L. Bourke) independently wrote reflection notes and shared them with the other three authors. These served as contemporaneous reflective accounts of the process. A conceptual framework of rural and remote health in Australia (Bourke, Humphreys, Wakerman, & Taylor, 2012a) was utilised as a tool to relate these written reflections to rural health. Once the research agenda had been developed, authors L. Bourke and J. R. Wright discussed their written reflections with each of the other authors independently. In this article, the Chair and the facilitator are considered internal to the process as they participated in the task group. Author L. Bourke is also a co-author of the rural and remote health framework employed in this study. The remaining authors (J. D. Best, J. Wakerman, and J. S. Humphreys) are considered external to the process as they were not involved in the task group. The three external authors include one senior professor at the same university who oversaw the RHAC but had no role in the task group (J. D. Best). The remaining two external authors are the co-authors of the rural and remote health framework utilised. They had not taken part in the research agenda development process and worked at other universities (authors J. Wakerman and J. S. Humphreys). The three external authors did not have first-hand experience of the research agenda development process; they had to depend on the reflective accounts of the Chair and the facilitator, the internal authors.

From the written reflections and subsequent discussions with the external authors, the following reflections highlight key issues in the development of a research agenda. The reflections focused on engagement of staff members, power of individuals driving the process, and use of the rural and remote health framework. Quotations from the written reflections and discussions among the authors are used in the reflections and discussion below.

4.1. Engagement Levels

It was clear that engagement in this process varied. While 28 staff members selected this task group, eight attended the final meeting. The facilitator noted that more staff attended the first two meetings, when the goal was less clear and the discussion was less focused. Not only did attendance vary but commitment to the process, time invested in the process (developing proposals, talking to colleagues), and passion to have a say in the research agenda also varied, and these did not necessarily correlate. Both the Chair and the facilitator inferred that few wanted to make decisions. A total of 23 of the 28 participated through meetings, with more senior and full-time staff engaging in the process in more committed ways. Junior staff, Aboriginal staff, and professional staff engaged less in the later stages of the process, perhaps due to a lack of confidence in setting a research direction rather than a lack of interest.

The inclusion of 10 professional staff members in the research task group hints at their interest and engagement in the development of a research agenda. The engagement of these people gave a voice to those individuals living in rural communities (see Conway & Dobson, 2003; Graham, 2012) as well as part-time clinical staff members who worked in

other health services and represented partners in the RHAC's research projects. The drivers of the process felt that the contributions of the professional staff in discussions of the research agenda were insightful and their participation in the research task group was important.

Based on the eight written reflections, both the Chair and the facilitator felt that most staff members, particularly the academics, focused on short-term research outcomes and wanted to undertake research on the topics that they were currently researching. They also noted that there was little discussion of evidence, seeking new directions, developing collaborations, interdisciplinary approaches, researchers growing over time, or a long-term plan. Both felt that development of a research plan was not rejected by the academic members of the task group but collaboration and planning were not engaged in meaningfully. Most wanted to continue the research they were currently doing using the same approaches while simultaneously stating they wanted more collaboration and less isolation. This suggests that engaging researchers in a process of change requires considerable work and their willingness to adjust their focus of research; a task not easy to achieve and possibly hindered by the time frame. An agenda was only the beginning of this process of change and engagement in genuine collaboration seemed to lack depth or sustainability.

Those individuals who were external to the process were not concerned about the level of engagement by staff members. They focused on opportunity, indicating all staff had had the opportunity to shape the research directions of their department. These independent authors viewed the process as rational ("difficult to disagree with"), open, inclusive, timely, and fair. They saw this as a process that "allowed for negotiation" and "a transition from individual research to a team approach." Each of these external authors suggested that a lack of staff engagement was due to no fault of the process but perhaps more a resistance to change. One questioned if the facilitator expected engagement by all staff selecting the task group and if this was realistic. In sum, there were differences in expectations of engagement by those people driving the process and the authors external to it. Drivers of the process had anticipated that most researchers in the centre would want to be involved in determining the direction of their work. Those external to the process viewed the new research agenda as the beginning of long-term change and they expected resistance.

4.2. Power and Influence

The written reflections questioned the influence of the Chair and the facilitator in the process, particularly in relation to the degree the two had shaped the three research themes. Workforce had been an obvious theme for the RHAC and was initiated independent of the Chair and the facilitator. Consensus was gained quickly, despite not having a written proposal. However, the two remaining themes had been shaped by either the facilitator or the Chair and they both reflected on how much they had shaped the discussion and the agenda emerging from it. They reported feeling uncomfortable with the extent to which they had shaped the outcomes of the research agenda.

Each of the three authors external to the process independently suggested that the academic members of the task group seemed to protect their patch and struggled to engage in a long-term planning process. The external authors felt that the process needed key individuals to drive or lead it. They suggested that as senior researchers in a small centre, the contribution of the Chair and the facilitator to the content of the research agenda was important. The external authors talked about how power was inherent in this process, in who chose to participate, the levels of participation, the decisions made, and the roles of the Chair and the facilitator. They agreed with the sentiment that the process exemplified a leadership initiative that achieved a research agenda in a timely manner, through an inclusive process. In sum, the external authors suggested that the inherent power of the Chair and the facilitator was evident, not problematic and essential to the process.

The written reflections also noted the amount and role of debate. Having individuals question or reject ideas sparked discussion, leading to further considerations and sometimes further clarification or a stronger argument for the idea. This debate, however, may have discouraged participation by others uncomfortable with critical discussion. The external authors indicated that because response to a specific idea created discussion, it was important that senior researchers proposed ideas (see Hecht, Higgerson, Gmelch, & Tucker, 1999). They also noted that the occurrence of lively discussion and debate suggested that the participants had opportunities to shape the agenda.

4.3. Interpreting the Research Agenda

To interpret the research agenda, it was considered important to relate it to the research field. This was done by placing the research themes within a conceptual framework of rural and remote health (Bourke et al., 2012a). This framework suggests that most rural health situations (issues, services, policies, and actions) can be explained through the interaction of six components (Figure 1):

- (a) *Geographic isolation* from other services and centres
- (b) *Rural locale*, the people who live in the place including their actions, health behaviours, local groups, norms, and so forth
- (c) *Local health responses* comprising local health services and other local actions relevant to health
- (d) *Broader health systems* including health policies, the funding of health services and programs, and broader protocols of health care and service delivery
- (e) *Broader social structures* or structural issues that impact on health and create knowledge about the rural
- (f) *Power* at all levels including agency and action of individuals and groups as well as social structures that reproduce particular health actions

These six components are viewed through the sociological lens of *structuration*. The concept of structuration refers to the dynamic and multilateral processes by which social actors both reproduce and transform the very social structure which constrains them (i.e., the so-called duality of structure and agency) (Giddens, 1986). Used in the context of the above framework, structuration offers a way to understand how the six components work simultaneously and in an integrated way (Bourke et al., 2012a). For example, a newly

elected government influences health programs/funding that have implications for rural and remote health services and communities. These services and communities will be impacted differently based on their geographic isolation, the ability of local actors to change, and the degree to which the new government is “rural and remote friendly” (which is a product of the power of rural and remote electorates).

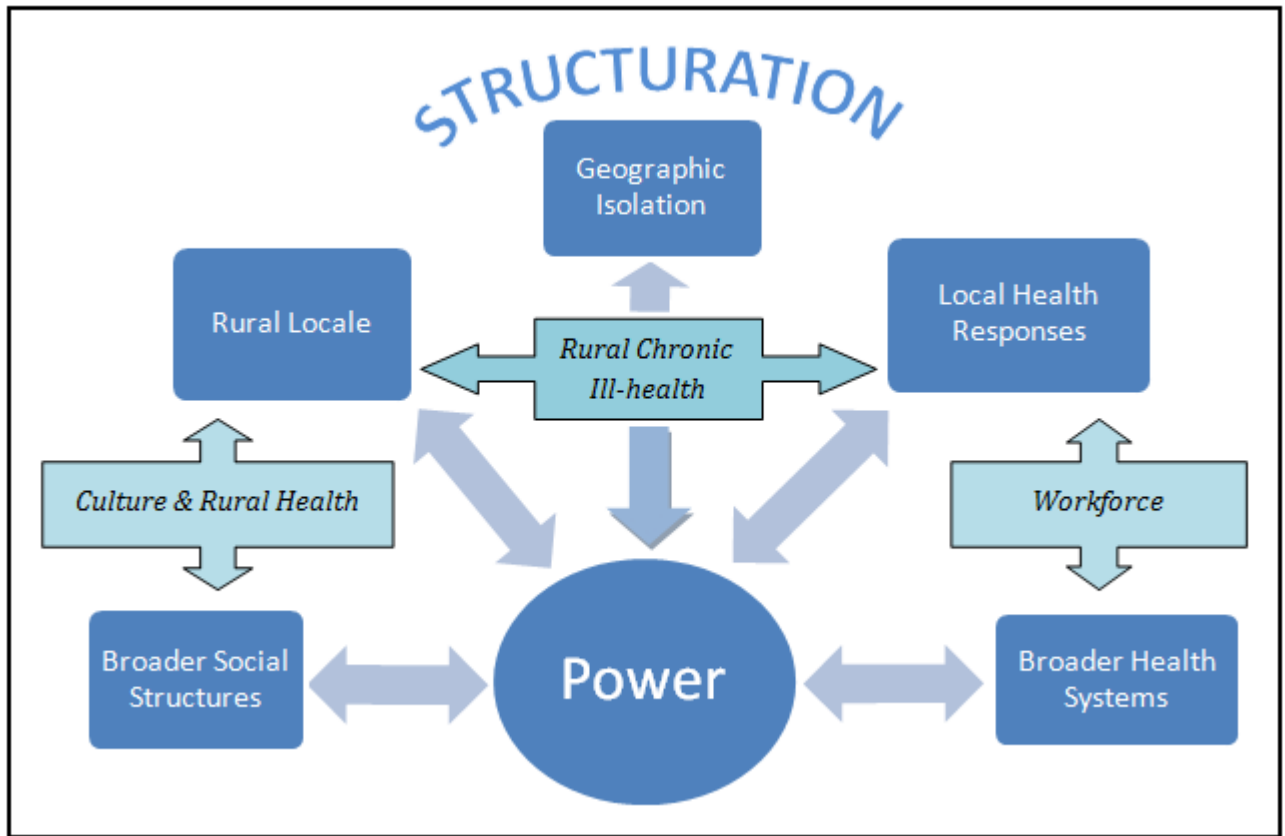


Figure 1. The conceptual framework of rural and remote health in Australia with the research themes identified (Bourke et al., 2012b).

Note.

Geographic Isolation: The rural space as it impacts on the other five concepts

Rural Locale: Social relations, interactions, and actions of the local people in the space

Local Health Responses: Actions of local services, professionals, or community groups relevant to health

Broader Health Systems: State/national organisations, health evidence and knowledge, health policy, and other political systems that shape health locally

Broader Social Structures: Structures and structural constraints resulting in health inequalities

Power: Occurring in all social relations, influencing action and (re)production of social practices

Structuration: Structuration connects individual actions and broader social structures within each of these concepts and provides a perspective on power (Giddens, 1986).

This framework has been applied to rural situations to explain the drivers of, and resistance to, change and how change in rural health requires both local level and structural or health systems level changes (Bourke, Humphreys, Wakeman, & Taylor, 2012b). Here the framework is applied to the discussion of rural health in each of the four meetings, to assess how the content of these discussions and the research agenda fit within the relevant field.

Both the internal authors noted that the research themes could be easily positioned within the framework (see Figure 1) and that this seemed to identify their significance as relevant areas of inquiry in rural health. The written reflections and discussions with external authors all indicated that all components of the rural health framework were included in the research agenda, although some more prominently than others (see Table 2). The reflections also suggested that the three research themes emphasised different components in the framework and focused on rural contexts of, and macro structures impacting on, rural health. That is, while workforce research focused on health at the local and macro levels, culture focused on the social dimensions locally as well as broader social structures, and chronic ill-health focused on the local people and health services they receive.

In their peer reflections, all authors agreed that most researchers were focused on one or two areas of the framework and did not situate their research across the entire framework or broader rural health context. The Chair and the facilitator noted that discussions focused on the rural locale with less talk about geography and local health responses/services. The external authors noted a lack of detailed discussion of the structural components and agreed that the rural locale was the primary focus of the emerging research agenda.

Table 2. *Applying the Framework of Rural Health in Australia to Discussions of Developing a Research Agenda*

Framework Component	How the Discussion Reflected the Framework Component
Geographic Isolation	<ul style="list-style-type: none"> • in terms of local geography and local areas (not as rural generally) • rural centre viewed as disadvantaged, isolated from main university <p>Discussed in negative terms as a source of problem and a barrier to be overcome, and also as a constant, not variable</p>
Rural Locale	<ul style="list-style-type: none"> • as people to conduct research on/with • in terms of health needs of particular people • as a type of patient ("the rural patient") • as impacting upon health • as cultural • equated with "community" • discussion of chronic disease (aging population with poor health behaviours) • discussion of culture (cultural diversity, access issues, health needs) <p>Discussed as passive participants that research could benefit</p>
Local Health Responses	<ul style="list-style-type: none"> • response of RHAC • health services as partners and collaborators in research • rural chronic ill-health prominent in these discussions <p>Health services are often partners in research and also benefit from research findings</p>

Framework Component	How the Discussion Reflected the Framework Component
Broader Health Systems	<ul style="list-style-type: none"> • undertaking research consistent with national health priorities • contributing to policy • rural health workforce theme critical to policies in rural health • building reputation of RHAC • connecting with larger university • utilising existing health evidence and applying in rural contexts <p>Facilitator suggested this was discussed but Chair indicated this was missing from many discussions</p>
Broader Social Structures	<ul style="list-style-type: none"> • not discussed frequently • structures seemed poorly understood; discussion unclear <p>Not thoroughly explored</p>
Power	<ul style="list-style-type: none"> • not discussed overtly nor named • relevant to discussions of funding, change, and the reputation of RHAC <p>Not named but power implied in discussion of all research themes</p>

For the Chair and the facilitator, the framework provided a means to relate the research themes to rural health as a field of research. Authors external to the process identified that the utility of the framework was its ability to situate the research agenda in the larger context of rural health. They suggested that the process had achieved a research agenda that sat within the conceptual framework, existing rural health funding programs, and research gaps. All authors believed that the three research themes approached rural health from different perspectives and comprehensively reflected major rural health issues.

5. Discussion

Most discussions associated with developing research agendas have focused on the content of the research agenda and the need for such knowledge to transform policy, awareness and/or practice (Becker et al., 2013; Gedajlovic et al., 2013). This article reflected on the process of developing a research agenda by two drivers of the research agenda engaging in reflective leadership (Burley, 2012) and was enhanced with external input from senior professors in the field of rural health. While limited by reflection of only a few, some insights were gleaned.

Questions arose about who drove the process, who made the decisions, who was active and passive, how power was used, leaders' roles within the process and the role of the conceptual framework of rural and remote health in Australia. Consistent with the conceptual framework, where power relations are central to outcomes in rural and remote health, power relations were also central to how this research agenda was developed.

Embedded in structures of government funding and university strategies, the Chair thought it was important for RHAC to build some key research foci in rural health. The goal was to meet both university and government expectations. The Chair designed a structure to enable the staff to develop a rural health research agenda. The facilitator embraced this process, also aspiring for staff engagement but overlooking existing power relations. Many

participants were active in the process but not to the extent anticipated by the facilitator, which may signal resistance, disempowerment, apathy, or alternatively agreement with the process. Regardless, the passive participants enabled the more active and vocal participants to decide on a research agenda, thereby (re)producing power relations within RHAC. This included active participation by both the Chair and the facilitator.

Reflecting on these power relations, this article raises questions about how to engage staff members in the process of developing a research agenda that is driven by senior researchers with vested interests. While the process aimed to enhance team collaboration, identify research foci, and develop a research track record, staff engagement seemed more focused on reproducing existing research practice. On reflection, the process may have benefitted from more discussion at the outset regarding reasons for developing a research agenda. Further, embarking on a longer process of interprofessional collaboration may have enabled stronger commitment to a research agenda and set up a process of change. In addition, a process for measuring participation and engagement would have enabled further understanding of the agency of actors in this process. Caution must be raised about assuming attendance is synonymous with commitment, or that absence means resistance (see Healy, 2000). Some active actors did not attend all meetings and some passive staff attended all or most meetings.

Both the facilitator and the Chair highlighted their concern that their formal power within the RHAC structure resulted in their strong influence as actors in the process. For the three authors external to the process, the influence of the Chair and the facilitator was expected, non-problematic, and a positive form of leadership/power. Clear definition of roles at the outset would have clarified the level of input of the facilitator and the Chair, and had these roles been clear with the group, this conflict of interest would have been largely resolved. What remains unclear is whether or not this research team wanted a research agenda and research leadership, if they were ready to develop a research agenda, and whether they were passively resistant or passively supportive of this process. While the Chair and the facilitator questioned their power in shaping the outcome, they did not question their power in designing and implementing the process. The need for a research agenda was largely assumed without regard for staff's readiness for change.

Utilising the rural and remote health framework in the reflective process seemed to provide a point of reference for all authors reflecting on this process. The framework provided a basis from which to review discussions at the four meetings, including what topics were missing, the relevance of topics to rural health, and whether the topics stemmed from a researcher's passion or a rural health need. Given both the Chair and the facilitator were disappointed with the lack of evidence and discussion of rural health and rural communities, utilisation of the framework provided a basis for critique. All authors noted that they found the framework to be useful in reflecting on the research agenda, however they acknowledged that the framework may have shaped the topics that were reflected upon.

As articulated by Giddens (1986), broader structures have a role in the (re)production of power relations at the micro level, and RHAC is no different. RHAC is part of a university embracing a planned, focused, and team approach to research. Contemporary research

universities tend to employ researchers to work in teams to address key issues that are then divided into specific research questions and projects. These teams have leaders or experienced researchers to lead projects undertaken by the team. The efforts of the team are rewarded but some team members fare better than others, despite effort and contribution. RHAC adopted this approach but developed broad themes recognising the generalist nature of rural health research and the diversity of research perspectives within the team. RHAC is government funded to achieve specific aims—research focused on rural health workforce and related research. In setting the research agenda, staff members were aware of this mandate and the first (and least disputed) theme agreed on was based on recognition of this broader aim. The research agenda reinforced government directives and university strategic directions that were key to the sustainability of RHAC. These power relations co-existed with the actions of some staff to shape the research agenda; the passive response by others enabled those who were more active to have their voices heard. Thus, a research agenda arose from actors who reinforced existing structures and simultaneously used agency to shape their future research. From this discussion, key lessons about planning the process have been identified:

- (a) More attention to clarifying the need for a research agenda at the outset may have achieved greater engagement.
- (b) Clarifying the role of the Chair and the facilitator would have been useful, given their positions of power at the Centre.
- (c) Inclusion of the perspectives of all staff in this reflection would have enabled more comprehensive reflection of the process.
- (d) Measurement of engagement would have provided useful data in the subsequent reflective process.
- (e) Identifying realistic expectations may have assisted with facilitation of, and reflection on, this process.
- (f) Identifying power relations at the outset might have helped in anticipating and addressing confusion of roles and influence as well as understanding the engagement of members.
- (g) More understanding of the team's readiness for change and willingness to embrace a research agenda would have been helpful.
- (h) Engaging in a longer process of developing research teams might have resulted in more commitment to, and interprofessional collaboration in, a research agenda.

6. Conclusion

The Chair of RHAC embarked on developing a research strategy in order to comply with university approaches to research and government approaches to funding. The strategy was not intended to be too restrictive but was intended on focusing all researchers on key areas of rural health so as to build a track record, attract further funding, develop a reputation for RHAC, and meet university and funding goals. While it was never intended that there would be consensus on all research themes, all staff were provided with the opportunity to influence the new themes. Some engaged in this opportunity, although many were passive. Regardless, three themes were decided upon that have remained the research foci of RHAC to date. This reflection focused on engagement of staff members in the process, the power of those driving the process, and the use of a conceptual

framework in the reflective process. Power relations underpinning the actors involved in this process as well as the structures constraining this process are key to how the research agenda was achieved.

The promotion of planned research among teams is a marked shift from earlier paradigms of academic freedom that allowed individual researchers to follow their own lines of inquiry. However, planned and team-based research is at times inconsistent with university appraisal systems that assess academic performance on the basis of individual achievements. Universities and governments audit, monitor, and assess researchers individually and competitively based on output, while also promoting some forms of team work and collaboration (Davies & Bansel, 2010). These inconsistent messages reflect different standpoints on research agendas. On the one hand, there are clear power differentials within research teams and research agendas can reinforce those power differentials. On the other hand, a research agenda can be effective for those wanting to learn from more experienced researchers, those seeking research directions, or for those whose interests align with the agenda. Where an individual's research interests or outputs do not fit the goals of the research agenda, tensions can result. Therefore, research agendas are embedded with power that can be viewed as suppressing academic freedom and innovative research, and/or understood as providing a framework for undertaking rigorous streams of research in a programmatic fashion while providing a training ground for new researchers.

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